

CONFRONTING COMBAT STRESS REACTIONS

BY

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USAWC STRATEGY RESEARCH PROJECT

CONFRONTING COMBAT STRESS REACTIONS

by

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ABSTRACT

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The continuous deployment of our forces over the past eight plus years has resulted in an alarming increase in the number of Soldiers developing symptoms of or being diagnosed with Traumatic Brain Injury (TBI), Post-Traumatic Stress Disorder (PTSD) or symptoms of long-term major depression. There are growing concerns regarding repeated deployments and the cumulative effects of combat stress reactions experienced by our forces that could eventually result in a significant reduction in the total number of Soldiers being available to support future conflicts. Senior leaders must rapidly recognize the stressors placed on the mental health and well-being of our Soldiers and their Families. Increased efforts are required to change both the mindset and culture of our senior leaders to ensure that adequate measures and programs are implemented to both support and assist our veterans, Soldiers, and Families in tackling these conditions now and in the future.

CONFRONTING COMBAT STRESS REACTIONS

Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and major depression are medical conditions that are increasingly associated with our military forces. For over 200 years, our Nation's Armed Forces have been actively engaged in numerous wars and conflicts around the world. Evidence suggests that the human dimensions of war and warfare, and the toll it takes on Soldiers when confronted with repeated deployments and stressors, has resulted in an increase in the number of Soldiers experiencing symptoms associated with TBI, PTSD, major depression, and other medical-related conditions. These conditions affect mood, thoughts, and behavior. Typically, these wounds often go unrecognized and unacknowledged. Far too often, individuals with these conditions suffer quietly, remaining invisible to other military personnel, Family members, and society in general.¹

There are growing concerns that the total number of Soldiers affected by these medical conditions far exceeds the numbers currently being acknowledged. Long after the dust settles and the continuous deployments of servicemen and women subside, we may discover that an overwhelming number of personnel are tormented by these illnesses. Evidence suggests that these illnesses are having a profound impact on Soldiers and leaders at every level. Like any known disease or illness, there are no boundaries; no one is immune from being diagnosed with major depression, TBI or PTSD. We owe it to our Soldiers and their Families who have made tremendous sacrifices on behalf of our great Nation to do more in finding ways to overcome the mental health challenges associated with multiple deployments. Pragmatically, we must

address these challenges because failure to do so may negatively impact the ability of our Army to successfully prosecute our Nation's future conflicts. In essence, the strategic implications associated with the growing number of Soldiers affected by these medical conditions may inflict a tremendous negative impact on the future readiness level of our Army.

In a recent interview, it was discovered that Army Staff Sergeant Bobby Martin Jr. has been fighting insurgents in Iraq and Afghanistan longer than the entire three years the Korean War was fought. Completing a fourth combat tour, SSG Martin has witnessed five of his men killed since 2003. Four died during his current combat tour, including two Soldiers who perished on SSG Martin's 34th birthday. Thirty-eight cumulative months in combat have left SSG Martin with bad knees, aching shins, and recurring headaches from a roadside blast.² The concern is that this young leader's continued exposure to the various invisible wounds of war will leave him and others with similar experiences vulnerable to developing both PTSD and major depression. A Rand report indicates that there are hundreds, if not thousands, of other men and women like SSG Martin who have also experienced similar circumstances during their repeated deployments.

It is imperative that our Army, as an institution, move swiftly in fully comprehending the tremendous challenges associated with mental health conditions while simultaneously working to change the internal culture of our Army to ensure change is inculcated effectively.

There has been scientific research and numerous studies conducted in an effort to better comprehend the various causes, identify preventative measures, and

determine proper treatments to effectively minimize or eliminate mental health conditions impacting servicemen and women engaged in war and warfare. Despite these efforts, servicemen and women serving in combat zones continue to develop symptoms of and being diagnosed with PTSD, TBI, and major depression at an alarming rate.

Defining Three Prominent Mental Health Conditions Affecting Soldiers

In order to effectively identify the competing factors that are compounding the mental health challenges facing our Army, we must first highlight the three prominent mental health disorders affecting Soldiers who are repeatedly exposed to war and warfare. The National Center for Post-Traumatic Stress Disorder defines PTSD as an anxiety disorder that can occur after an individual has been exposed to a traumatic event. These psychologically traumatic events can provoke intense fear, helplessness or horror, and typically are characterized by flashbacks, recurrent nightmares, hallucinations, intrusive memories, and avoidance of reminders of the event; depression and anxiety are often present.³

A number of studies have determined that TBI is the result of physical trauma to the head causing damage to the brain. The damages sustained as a result of TBI can be focal or restricted to a single area of the brain or more diffused, affecting more than one region of the brain. By definition, TBI requires either a head injury or any physical assault to the head leading to injury of the scalp, skull, or brain.⁴

Combat stress reaction is categorized as a range of behaviors resulting from the stress of battle which decreases an individual's fighting efficiency. It is reported that the most common symptoms of combat stress reaction are fatigue, indecision, slower reaction times, inability to prioritize and disconnection from one's surroundings.⁵

Some Historical Findings That Brought Mental Health Disorders To The Forefront

History has consistently determined that the psychological wounds of war are the leading cause of casualties sustained in combat environments. It has been recognized that exposure to war and warfare can negatively impact the mental health of anyone serving in these environments. In 1983, the National Vietnam Veterans Readjustment Study (NVVRS) discovered approximately 15.2% of men and 8.5% of women who served in Vietnam had PTSD features 20 years after the war and another 11.1% had partial PTSD. The report also reveals the total of 830,000 veterans who had symptoms and related functional impairments associated with PTSD during the 20 year period. While the actual number of Vietnam veterans who developed these conditions is imprecise, it is estimated that approximately 30.9% of men and 26.9% of women suffered from PTSD at some point in their life following Vietnam.⁶

In his book, "Stress Disorders Amongst Vietnam Veterans," David Figley explains how the various symptoms veterans were experiencing demonstrate the basis for our significant concern associated with the number of veterans suffering from PTSD and major depression. Mr. Figley points out that a study conducted during this period concluded that 67% of Vietnam veterans reported frequent nightmares, 32% had difficulty in relaxing, 35% had trouble in getting close to people, 35% were fearful, 28% nervous, 32% felt they tired too quickly, and 41% felt themselves to be short tempered or hotheads, etc.⁷

These rates are alarming since they indicate that at the time of the study, there were about 479,000 cases of PTSD and one million lifetime PTSD cases as a result of the Vietnam War. The most common symptoms shared by Vietnam veterans with PTSD include (1) feelings of guilt that often turned to self-punishment, (2) feeling as

though they were scapegoats and/or victims of betrayal by country and government, (3) experiencing rage aimed at discriminate and indiscriminate targets, (4) psychic numbing or emotional shutdown, (5) alienation from themselves and others, and (6) doubt in their ability to love or trust others.⁸

Psychological studies conducted after the Vietnam War era revealed that nearly 15% (435,000) of servicemen and women who served in combat roles during that conflict suffered PTSD. These studies found that nearly 30% of Vietnam War veterans developed psychological problems after returning from the war.⁹ Despite the brief period in which the Persian Gulf War was fought, the NVVRS contends that the rates of PTSD range between 9% and 24%.

Data compiled by the NVVRS also reveals that of the 1,632 Vietnam veterans in the study, 432 were women who had served in and around Vietnam from 1964 to 1975. This study determined that 27% of female Vietnam veterans suffered from PTSD during their postwar lives. By comparison, 31% of male Vietnam veterans were properly diagnosed with PTSD.¹⁰

Past as Prologue: PTSD Then and Now

Soldiers supporting the Overseas Contingency Operations (OCO) in Afghanistan and in Iraq are experiencing the same symptoms exhibited by our veterans who served in Vietnam and other conflicts. Since the initial start of combat operations in Afghanistan on 7 October 2001, which later expanded to include the conflict in Iraq on 19 March 2003, the total number of American deaths in Operation Iraqi (OIF) is 4,370 and a total of 31,575 wounded in action (WIAs). In Operation Enduring Freedom (OEF), there were 925 deaths and 4,606 WIAs.¹¹ These figures are current as of 4 Dec 2009.

The casualty figures above suggest that OEF/OIF has become the deadliest American conflict since the Vietnam War. The effects of OEF and OIF on the mental health of our servicemen and women is beginning to be revealed; nearly 13,000 of the 240,000 veterans of Iraq and Afghanistan already discharged from service have been seen by the U.S. Department of Veteran Affairs (VA) counseling centers for readjustment problems and symptoms associated with PTSD.¹² New data reveals that 17% to 18.5% of service men and women returning from Iraq reported PTSD symptoms while about 3% to 4% reported other mental distress. Additionally, a new Army study found that 11% of our Soldiers returning from Afghanistan reported symptoms of mental distress.¹³

Dorian De Wind, Professor of Management Science at Stanford Graduate School of Business, contends that while an Army Medical Health Advisory Team found that 17% of service members returning from Iraq and Afghanistan suffer from PTSD, and a Rand study put the number at 18.5%, his study found that “about 35% will ultimately suffer from PTSD.” He also states that “approximately 300,000 servicemen and women currently suffer from this condition, with 20,000 new sufferers for each year the war lasts.”¹⁴ For example, through January 2009, nearly 9,000 U.S. troops in Iraq or Afghanistan had been evaluated or treated for TBI; and a recent study by the Rand Corporation estimates that at least 180,000 and as many as 360,000 U.S. troops serving in these wars may have sustained head trauma capable of causing brain injury.¹⁵ Additionally, the Rand Corporation has estimated the percentages of service members returning home from both Iraq and Afghanistan who suffer from PTSD, major depression, and TBI (see Figures 1 & 2 below).

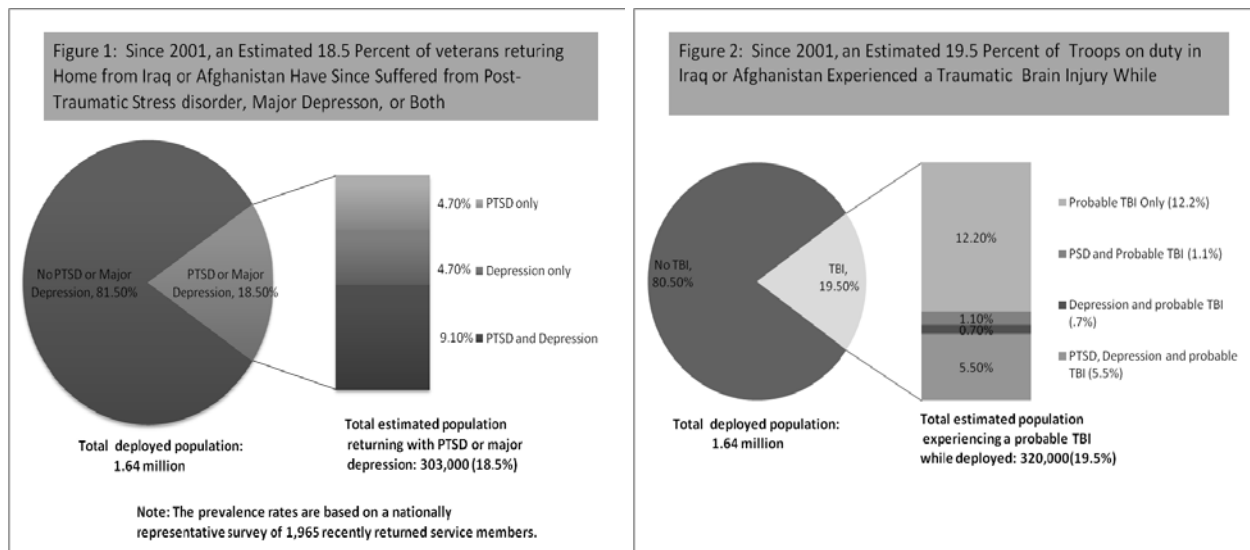


Figure 1 & 2: Percentage of Soldiers Suffering from PTSD, major depression and TBI¹⁶

These figures cover the period 2001 through 2008 and suggest that an estimated 18.5% of veterans returning from Iraq and Afghanistan have suffered PTSD, major depression or both, while an estimated 19.5% of troops on duty in Iraq and Afghanistan experienced TBI.

The Rand study also suggests that current rates of exposure to combat trauma and mental health conditions among returning veterans are relatively high. Rates of exposure to specific types of combat trauma ranged from 5% to 50%, with high levels of exposure reported for many traumatic events.¹⁷ Vicariously experienced trauma (i.e. having a friend who was seriously wounded or killed) is the most frequently mentioned. Other traumatic experiences include (1) seeing dead or seriously injured non-combatants (2) witnessing an accident resulting in serious injury or death (3) being injured and/or knocked over by an explosion (4) smelling decomposing bodies (5) being physically moved or knocked over by an explosion (6) and engaging in hand-to-hand combat.¹⁸ The study concludes that approximately 50% of Soldiers who require treatment for PTSD seek it, but many of them receive less than adequate care.

Several studies (including reports done by Rand and the National Council on Disabilities) report that many veterans and active service members who require treatment for PTSD fail to seek help due to various stigmas of how they would be perceived if they sought help for their mental health condition. These reports also conclude that due to the increased number of people requiring treatment, the VA and other medical facilities are understaffed with qualified psychologists and psychiatrists who are trained and experienced in treating mental health conditions.

Another study looked at service members assigned to four combat infantry units (3 Army and 1 Marine) who had served in Iraq and Afghanistan. The majority of the service members serving in these units were exposed to some kind of traumatic, combat-related situations, such as being attacked or ambushed (92%), seeing dead bodies (94.5%), and/or knowing someone who was seriously injured or killed (86.5%); experiences that are associated with increases rates of PTSD. After deployment, approximately 12.5% had PTSD, a rate greater than that found among Soldiers before deployment.¹⁹

Major depression, PTSD, and TBI are not just impacting male Soldiers; these illnesses are also affecting female Soldiers at an alarming rate. Although the Department of Defense prohibits female Soldiers from serving in combat arms Military Occupational Specialties (MOS), the asymmetric threat in which we have encountered over the past eight plus years have placed them in the midst of combat. Approximately 15% of all military personnel serving in Iraq are women. Female Soldiers serving as Military Police, pilots, drivers, gunners embedded within convoys and various other MOS's have experienced combat first hand.²⁰

A recent study conducted by the National Center for PTSD suggests that women in the military are at a higher risk for exposure to traumatic events in their lifetime. These factors are resulting in a steadily increasing number of female Soldiers being diagnosed with major depression, TBI and PTSD. This study also found that 20% of women supporting major operations in Afghanistan and Iraq have been diagnosed with PTSD.²¹

An informal survey conducted by health care providers at Walter Reed Army Medical Center and Bethesda National Naval Medical Center discovered that approximately 13% of active duty patients with PTSD are women. Thirty-five percent of health care providers revealed that their female patients reported more depressive symptoms than their male patients. Statistics show that of the over 230,000 female Soldiers who have served in support of OEF/OIF, 630 female Soldiers have been wounded and another 120 have died. Additionally, female Soldiers have experienced much higher rates of divorce and are more likely to be a single parent. Some studies have shown that female veterans are at a greater risk for homelessness.²²

Brigadier General (Retired) Evelyn Foote, President of the Nonprofit Alliance of National Defense in Alexandria, Va., contends that the combat zones in which we are currently operating in have no set boundaries. This dynamic has resulted in female Soldiers experiencing greater exposure to various combat related incidents similar to direct combat. Without warning, female Soldiers traveling in convoys can be hit with IEDs and suffer various combat-related injuries, including TBI and traumatic amputations. Additionally, they are subject to witnessing fellow comrades being seriously injured or killed.²³ Like all Soldiers who are exposed to combat, they will, in

many cases, experience long-term memories (psychological effects) of circumstances they witnessed and endured. These memories include the loss of comrades, the experience of pain, and the memories of fear; all of which increases their risk for PTSD. Many other studies over the years suggest that the effects of combat could transcend the battle itself and affect people long after the conflict.

Over the past eight years, the suicide rate in our Army has steadily increased. The alarming number of Soldiers committing suicide is not a new phenomenon. We have witnessed this type of trend following the end of past major conflicts and wars. For example, after Vietnam, it is estimated that anywhere between 50,000 to 150,000 Soldiers and veterans committed suicide.²⁴

During the summer of 2009, the number of Soldiers who had taken their own lives surpassed that of our civilian peers for the first time.²⁵ Studies have shown that people with a diagnosis of PTSD are also at greater risk of attempting suicide. Among people who have had a diagnosis of PTSD at some point in their lifetime, approximately 27% have also attempted suicide.²⁶ A Mental Health Advisory Team (MHAT) study reported that since the beginning of OIF, 162 confirmed suicides occurred within the deployed theater alone. In 2008, Multi-National Forces – Iraq (MNF-I) confirmed 34 theater wide suicides resulting in an annual theater rate of 21.5 per 100,000 U.S. service members deployed to the region.²⁷

Some Stigmas Causing Soldiers Reluctance In Seeking Mental Healthcare

Stigma has proven to be the primary impediment that prevents Soldiers from seeking mental health care assistance. Although our Army is encouraging our Soldiers to come forward in seeking medical support for their illnesses, many are still potentially reluctant to fully reveal the true nature of their medical problems due to either fear of

reprisal or forced to separate from the military prematurely. According to a report issued by the Department of Veterans Affairs, veterans' fears regarding possible impact on career prospects are based in reality; some will be judged medically unfit to return to duty.²⁸ Veterans may be concerned that a diagnosis of PTSD, or even Acute Stress Disorder in their medical records may harm their chances of future promotion, lead to a decision to not be retained or affect the type of discharge received.²⁹

During a 2009 annual report conducted by the Mental Health Advisory Team (MHAT) VI, the team discovered a significant stigma factor affecting Soldiers' decision to receive mental health services. The report reveals that 37.1% of Soldiers assigned to combat maneuver units and 28.5% of Soldiers assigned to combat service support (sustainment) units believe that revealing their mental health medical condition would be considered too embarrassing. The study found that 34.4% (maneuver) and 26.2% (sustainment) of Soldiers believe that making their mental health conditions known would be harm to their careers. Another 48.8% (maneuver) and 37.4% (sustainment) of Soldiers believe that members of their unit might have less confidence in their abilities. Alarming, 54.4% (maneuver) and 45.4% (sustainment) of Soldiers believe that coming forward would cause their leaders to treat them differently. The study also indicates that 42.9% (maneuver) and 32% (sustainment) of Soldiers believe that their leaders would blame them for their mental health problems. Additionally, 52.6% (maneuver) and 39.9% (sustainment) of Soldiers believe that receiving mental health services would be seen as a sign of weakness.³⁰ The Rand study outlined below in figure 3 further supports these conclusions.

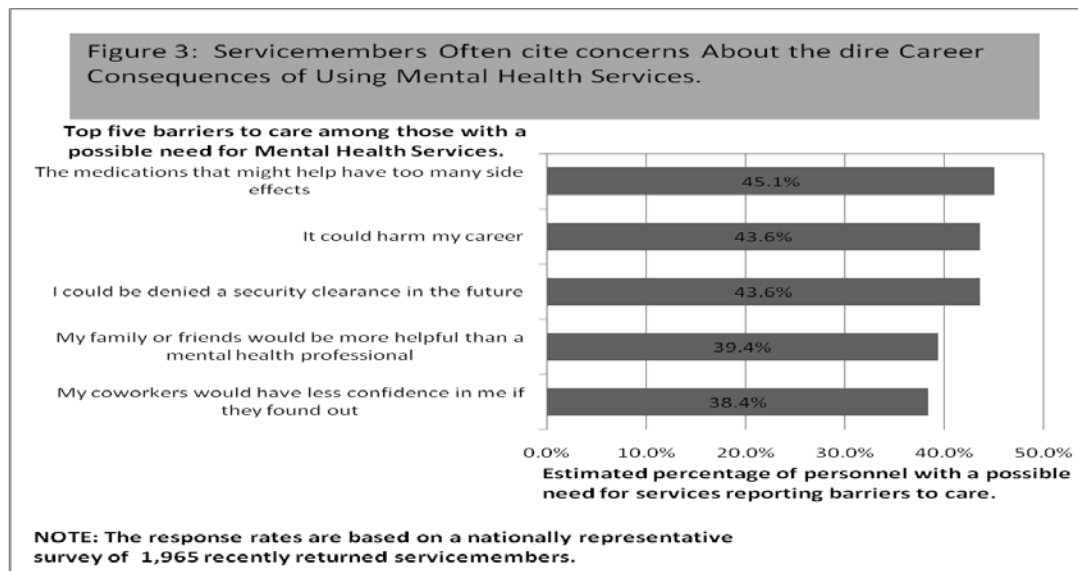


Figure 3: Service members concerns about seeking mental health services.³¹

To further compound Soldiers stigma with seeking help for their mental health conditions, the recent horrific tragedy that occurred at Fort Hood, Texas revalidates the need for more focus placed on caring for our Soldiers and their families. Furthermore, the nature of this incident, in terms of identifying Major Nidal Malik Hasan as allegedly responsible for this tragedy, may also cause a significant setback in providing Soldiers with a sense of confidence in coming forward to seek help in confronting their combat stress reactions, mental disorders, and medical challenges (see details of this incident in endnote).³² This also creates a potential setback in our Soldiers' confidence in seeking mental health assistance is a result of the alleged suspect being a commissioned officer and a psychiatrist; a trusted steward and servant who is suppose to help Soldiers and Families in overcoming psychological disorders. Regardless of whether this was a random act of violence, terrorist related or due to suicidal tendency, this tragedy has potentially resulted in Soldiers becoming more skeptical in revealing their mental health and medical challenges. As mentioned above, Soldiers are already

facing mounting stigmas (barriers) in their reluctance to seek mental healthcare support for their illnesses which include their concerns with regards to what seeking help may cause to their careers.

Mental Health Conditions May Also Be Affecting Senior Leaders

Mental health related illnesses are not just distressing Soldiers, they may also be affecting leaders at every level. As stated earlier, these illnesses have no boundaries. No one is excluded from developing these conditions. In his USAWC Strategic Research Paper, Colonel Mark A. Murray, United States Army, acknowledges that three months after changing battalion command and 16 months after returning from a tour in support of Operation Iraqi Freedom I, he was diagnosed with symptoms of PTSD (see timeline covering each phase of Operation Iraqi Freedom at endnote).³³ COL Murray admits that after being diagnosed with symptoms of PTSD, he thought of retiring from the U.S. Army. He further expressed, "I privately saw myself as damaged goods, guilty over the loss of my Soldiers, unfit for duty, and went against the guidance of my wife and supervisor, and submitted my retirement paperwork."³⁴ Without question, Colonel Murray made a bold and courageous decision in not only accepting, acknowledging, and moving forward in seeking assistance for his diagnosis, but by making a conscious decision in bringing his symptoms of PTSD to the forefront. COL Murray's willingness to produce a research paper on this topic reinforces the reality that leaders at every level are at risk of developing these conditions. His diagnosis is not an isolated case. Furthermore, it sends a critical message to leaders throughout our Army that we must fully recognize and comprehend that these illnesses are real. They will have strategic implications to our institution, as a whole, if not acted upon with a sense of urgency and prominence.

Just like our Soldiers, many of our leaders have been exposed to the frictions of war and the devastating affects war and warfare impose on the mental and psychological tendencies of human behaviors. Like junior Soldiers, many of our leaders are reluctant to come forward in seeking help and a comprehension of the feelings they are experiencing primarily due to the images we as leaders must embody. Many leaders may be in denial that they can be or are affected by these medical illnesses:

Yes, as a United States Army tactical focused operations tracked officer, I was shocked, embarrassed, and stunned by this diagnosis. However, deep in my heart of hearts, I can now look back and say I was truly relieved to hear the news. Quite simply, I was relieved because I had not felt right for a very long time, but now I knew and sort of understood why.” “Furthermore, as I have walked the hallways of Root Hall and sat among my brothers and sisters in Seminar 11 and Bliss Hall over the last nine months, *I have quietly wondered to myself about how many of them need to truly start feeling better and feeling right again [emphasis added]*.³⁵

Yet, many believe that their careers, as they know it, may be over if they come forth in seeking assistance and accepting professional findings that they are suffering from symptoms of, or are diagnosed with major depression, PTSD, and TBI. If these conditions go untreated, they can cause long-term complications for Soldiers and leaders.

Many of our experienced leaders, both NCOs and officers, are making conscious decisions to transition from the military (either by retiring or normal separation after stop loss/stop move restrictions are lifted). Every branch within our Army has been affected by an increased number of leaders declining commands at battalion and brigade levels. A Government Accounting Office (GAO) report concludes that the Army is continuously experiencing decreased retention rates among officers early in their careers who are graduates of the United States Military Academy (USMA) and Reserve Officer Training Corps (ROTC) programs. Many of these officers are returning from deployments and

discovering that the units in which they were selected to assume command of were preparing to deploy on their rotations. As a result, many are declining command, and often making the decision to retire in order to focus their efforts on re-building their relationships with their Families.

Inexperienced Leaders Are Being Thrust Into The Role Of Making Critical Decisions:

The GAO report also reveals that due to the continual problem the Army is facing retaining mid-grade officers, its decision to promote officers faster than normal is resulting in a reduction in time available for junior officers to master their duties and responsibilities at the Captain rank. Additionally, the Army has elected to select a high percentage of officers for promotion who would have been otherwise deemed “not qualified” due to prior performance indicators. The 2007 GAO report also found that the Army promoted 98% of eligible First Lieutenants, which is more than its goal of 90%; and promoted 97% of Majors which is more than the Army goal.³⁶ These increased percentages for promotion remained constant for FY2008, FY2009, and is projected to remain at this level during FY2010. These selection rates include promotions to the rank of Lieutenant Colonel. This report further suggests that the Army does not have a strategic plan for managing its shrinking accessions pipeline at a time when the force is expanding and its needs for commissioned officers are increasing.³⁷ The cumulative effects associated with these challenges are resulting in inexperienced leaders (in some cases, unqualified leaders) being given even greater (enormous) responsibilities.

Our young leaders, both NCOs and officers, are facing tremendous demands and challenges with insufficient experience, training, mentorship, and guidance. To compound this problem, deployments in support of these simultaneous conflicts have delayed their attendance to professional development schools, such as the Primary

Leadership course (PLC), the Basic Non-Commissioned Officers Course (BNCOC), the Advanced Non-Commissioned Officers Course (ANCOC), and the Sergeant Majors Academy for NCOs. Additionally, attendance at the Captains Career Course (CCC), the Intermediate-Level Education (ILE), the Senior Service College (SSC) and other branch unique professional courses intended for commissioned officers is being delayed or waived. In his recently approved Leader Development concept document, GEN Casey expresses the need to balance our commitment to the Training, Education, and Experience pillars of development as well as the need to prepare leaders for hybrid threats and full spectrum operations through outcome-based training and educations (see endnote for GEN Casey's 8 Imperatives).³⁸

Some Examples of Cumulative Effects Impacting Families

Our Nation continues to witness the enormous strain deployments and exposure to war and warfare over the past 8 plus years has imposed on Soldiers and their Families. In many cases, the Soldier who deployed a year ago is not the same Soldier (mentally, physical or psychologically) returning home to their loved ones. Conversely, as a result of single-handedly assuming the overwhelming responsibilities of managing all personal affairs to include becoming geographical single parents, many spouses of our Soldiers are also not the same "dependent" individuals left behind as they deployed.

Although established reintegration programs have been extremely helpful in assisting Soldiers and Families, our military is still experiencing escalations of violence and/or problems within our Families as they attempt to reunite and move forward with their lives. For many Families, the excitement of homecoming assumes that everything will immediately revert back to the way it was prior to deployment with nothing changing. In reality, their absence created a painful void within the Family system that was

eventually filled (or denied) so that life could continue. The Family assumes that their experiences at home and the Soldier's activities on the battlefield will be easily assimilated by each other at the time of reunion and that they will quickly resume their pre-war roles.³⁹ Soldiers return home expecting to reassumes roles they gave up prior to deployment. However, many quickly discover that their spouses are not prepared to relinquish their new roles.

These issues and other challenges have led to an increase in divorce rates, suicide ideations, and abusive environments as well as with psychological and mental challenges. Additionally, continued deployments are having a profound negative impact on our kids. During a testimony before Congress, Mrs. Sheila Casey, the spouse of General George Casey stated the following:

Families are so stressed everything is becoming an issue. Couples who have seen their marriages deteriorate don't have time to get divorced. I am...seeing signs of a force under immense strain, and this concerns me greatly. These indicators include cases of domestic violence, child neglect as well as increases in suicides, alcohol abuse and cases of post traumatic stress. The strain is especially acute on our young, newly married Army Families because, with repeated deployments bearing down on them, these young Families don't have enough time together to build a strong bond. So, they are particularly vulnerable to be stressed by the war. What keeps me awake at night is the cumulative effects on children of repeated deployments by parent Soldiers. The cumulative effects of nearly eight years of war will not be easy to reverse. My concerns are that we are going to see these things appear again later when Families have the time to really reintegrate.⁴⁰

Strategic Leaders Recognize the Cumulative Effects of a Protracted War

Strategic leaders at the highest levels of our Army, including the Army Chief of Staff, GEN George Casey Jr., and Army Vice Chief of Staff, GEN Peter Charielli, embrace and acknowledge that our Soldiers are developing mental health conditions at an alarming rate. In a statement provided to *Army Times*, GEN Charielli stated:

Since becoming the Vice Chief of Staff of the Army in August 2008, cases for PTSD and TBI have risen from 38% to 52% among Soldiers who have been involved in incidents in Afghanistan and Iraq...about 30% of Soldiers sent downrange will have some form of Post-Traumatic Stress Disorder.⁴¹

These conditions are real and require acceptance and endorsements at every level of our leadership. This change in culture must be a “Top-Down” approach. As part of his “Guidance for 2009-2010,” Admiral M.G. Mullen, Chairman of the Joint Chiefs, states the following:

Our culture must value and support a continuum of care that lasts for a lifetime, and encompasses military members, retirees, and their families. Making that culture shift will require constant attention and cooperation between myself and the Chiefs, and close work with the Office of the Secretary of Defense and the Department of Veteran Affairs. I am concerned that we still do not have a holistic and clear way of measuring all the components of health-of-the-force, ranging from unit readiness, training, and age of weapon systems to retention / recruiting and personnel challenges, like suicide or divorce. In measures like dwell time, we still do not have sufficient fidelity below the unit level, down to the impacts on individuals and families. We do not have a common understanding of the time and costs to reset and reconstitute our forces- but just how fast and how well we reset will become a driver for global risk. We must make all of these a higher priority.⁴²

The rates for PTSD, TBI, and major depression are alarming and have prompted our Army to move forward in exploring better and improved ways to combat PTSD and other forms of combat stress reactions and to reduce the risk and impact of TBI. However, in order for these programs to succeed in maximizing their intent and purpose, our Army, as an institution, must move forward in changing our culture as it relates to how we view and support medical efforts designed to assist in treating these conditions.

Indeed, our Army is pursuing and exploring many programs to ensure Soldiers and their Families impacted by these critical conditions receive the best medical care and support. Additionally, there are a number of pre-training opportunities and

assessments to assist Soldiers and their Families in better conditioning themselves mentally and physically in an effort to minimize and/or prevent illnesses of this nature from developing or having long term consequences. However, leaders at the strategic level must not only embrace these illnesses as critical conditions affecting our Soldiers and leaders, we must move forward, as expressed by Admiral Mullen in his annual guidance, in embracing and implementing organizational cultural change, and inculcate this change throughout the leadership of our military. The time for changing our institutional culture by embracing and confronting combat stress reactions is now.

Internal Competing Factors Compounding The Strain On Our Force

For over eight years, our Nation and Armed Forces have been actively engaged in fighting in Overseas Contingency Operations (OCO) on two separate but distinctive battlefields, Afghanistan and Iraq. By doctrine, our Army has committed the majority of the ground forces supporting these conflicts. Through the implementation of the Army Force Generation (ARFORGEN) cycle, Army units have continuously rotated in and out of Afghanistan since October 2001 and Iraq since March 2003. The ARFORGEN process is intended to generate better trained, ready, cohesive personnel and resources, including manning and training, in order to deploy units as newly transformed modular (expeditionary) forces capable of meeting current and future strategic demands.⁴³ Although our Army has established a comprehensive deployment schematic detailing the ideal rotational criteria with a 1:2 ratio for active duty units and a ratio of 1:4 for Reserve and National Guard units, active duty units have been deploying on an average of 1:1 dwell time ratio (see endnote for explanation of ratios).⁴⁴ This pace has been maintained since 2004. In many cases, Soldiers have served on their

third, fourth, and even fifth deployment since the U.S. initiated combat operations in support of Operation Enduring Freedom in Afghanistan on 7 October 2001.

The cumulative effects of eight plus years of continuous deployments highlights one of several competing factors that have potentially placed a significant strain on Soldiers and their Families. These competing factors have caused our Army to be out of balance in terms of being able to effectively meet the demands for forces needed to support our “operating force.” In other words, the demands for our operating force continue to exceed the availability (supply) of units and Soldiers produced within the “generating force” (see endnote for explanation of operating and generating forces) .⁴⁵

In a statement before Congress on May 6, 2009, General George Casey stated the following:

Simply put, our Army is out of balance. The current demand for our forces in Iraq and Afghanistan exceeds the sustainable supply and limits our ability to provide ready forces for other contingencies. Even as the demand for our forces in Iraq decreases, the mission in Afghanistan and other requirements will continue to place a high demand on our Army for years to come. Soldiers, Families, and support systems are stressed due to lengthy and repeated deployments. Overall, we are consuming readiness as fast as we can build it. These conditions must change....⁴⁶

Supporting the complex and ambiguous demands associated with the war on terror, our Army is wrestling with two other major challenges: restoring balance to a force that is experiencing the cumulative effects of eight plus years of war and setting conditions for the future to fulfill our strategic role as an integral part of the Joint Force.⁴⁷

Our inability to meet these demands has resulted in our Army not being able to fulfill the deployment dwell time objectives established under the ARFORGEN process outlined above. Soldiers are spending an enormous amount of time deployed, and minimal time reintegrating with Families. In essence, this is continuing to one of the

major challenges facing our Army today; the overarching well-being of our force and our Families. It is imperative that we enhance dwell time by balancing length and frequency of deployments with time for Soldiers to reintegrate with their Families, and to provide more time to recover from medical and mental health illnesses they sustain in combat.

During an interview with *Military Magazine* General George Casey noted:

I've come to realize over the last two years that the single most important thing we can do to get ourselves back in balance is to increase the time that Soldiers spend at home. It's not just so they spend more time with their families (though) that's important. But it's also so they can recover themselves. I mean, a year in combat is draining, and the effects are cumulative. If you're going back 12 months after you've been there 12 months, you don't have time to fully recover. Comparing deployment with running a marathon, about two days later you feel ok. But if you went out and tried to run another marathon, you would hurt yourself, because you've broken your muscles down in ways you don't appreciate. That same thing happens with repeated combat tours.⁴⁸

Another major challenge is the significant transformation to modularity (infrastructure, restructuring and realignment efforts) in the midst of two prolonged wars has drastically minimized time available for recovery. However, these initiatives have been deemed vital in providing combatant commanders dominance and strategic responsive forces capable of meeting diverse challenges across the entire full spectrum of 21st century conflict.⁴⁹

It has also been determined that in recent years, three competing factors have drained current force strength: (1) the nearly 10,000 Soldiers assigned to warrior transition units; (2) another 10,000 Soldiers serving in transition teams or at headquarters; (3) and 10,000 Soldiers deemed temporarily non-deployable because of bad knees and shoulders; or due to the cumulative effects of multiple deployments.⁵⁰

During an interview with the *Military Officer* magazine, General George Casey states, "So there are 30,000 people who are not available for us. That means we were having

more and more difficulty getting units manned at an appropriate level for them to deploy.”⁵¹ In an effort to overcome this challenge, Defense Secretary Robert Gates announced plans in July 2009 to increase Army end strength in 2010 from the current 547,400 to 562,400 and peaking at a temporary cap of 569,400 by FY 2011; a jump of nearly 22,000 active duty Soldiers.⁵²

In conjunction with these initiatives, other competing factors involve the simultaneous execution of several additional major objectives including converting over 220,000 Soldiers from Cold War era occupational specialty skills to skills deemed more relevant to insurgency operations. Furthermore, we have undergone the largest rebasing of our Army since World War II (shifting approximately 280,000 Soldiers as a result of base realignments and closures, overall Army growth, and a significant drawdown of Army units from Korea and Europe).⁵³ In essence, compounding the lack of dwell time at home to fully recover from combat, two initiatives limit the amount of actual time Soldiers can pursue medical assistance or spend with their Families when they are not deployed. As the Army moves to modular units and converts 220K Soldiers from Cold War specialties to Information Age specialties, Soldiers who are not currently deployed may find themselves working long hours to accomplish transformational requirements.

Persistent conflict has increased the percentage of non-deployable Soldiers. This reduces our Army’s deployable strength and causes the need to man deploying combat units above normal manning strengths. These challenges forced the Army to implement a Stop-Loss/Stop-Move (SL/SM) program which becomes effective 90 days prior to a unit’s scheduled Earliest Arrival Date (EAD) into a deployed theater and

remains in effect up to 90 days after redeployment.⁵⁴ Instead of enforcing an involuntary SL/SM, the Army has implemented a monetary incentive plan to compensate Soldiers who extend their service beyond their scheduled obligation when assigned to units preparing to deploy. Throughout the length of a unit's deployment, replacement Soldiers are programmed to offset potential losses or reduction in the size of the deployed force.

A factor that also potentially places additional strain on our readiness level and on our force is the demands imposed on units that require them to deploy at a designated personnel manning strength. As stated earlier, eight plus years of persistent conflict continues to cause the operational force requirements to consistently exceed the supply of ready units and personnel (generating force). The Headquarters, Department of the Army Active Component (AC) Manning guidance for Fiscal Year (FY) 2008-2010 provides clear and definitive guidance on personnel manning for the Army during a period of persistent conflict; specifically, officer and selected enlisted military occupational specialty (MOS) skill shortages. An outline and summary of this guidance is provided below:

(1) Deploying Brigade Combat Teams (BCTs) and Combat Aviation Brigades (CABs) must be filled at greater than or equal to 90% assigned at Mission Readiness Exercise/Mission Rehearsal Exercise (MRE/MRX) minus 45 days; with 95% officers assigned at Latest Arrival Date (LAD) and 105% enlisted personnel assigned at LAD. It further requires commanders to manage non-deployable Soldiers to maintain a 95% deployed strength; CABs must be 100% assigned at LAD.

(2) Deploying Multi-Functional and Functional Support Brigade Headquarters and Operational Headquarters must be filled at greater than 85% assigned at MRE/MRX-45 days; with 100% assigned at LAD. It also requires these commanders to manage non-deployable Soldiers to maintain a 90% deployed strength.

(3) Deploying Sustainment Brigades Headquarters (SBs) must be filled at greater than 80% assigned at MRE/MRX-45 days; with 95% assigned at LAD; and requires commanders to manage non-deployable Soldiers to maintain an 85% deployed strength.

(4) All other deploying units not listed previously at the battalion, company or detachment level must be filled at 95% at LAD with units being required to manage non-deployable Soldiers to maintain 85% deployed strength (ensured by higher headquarters and/or installation).⁵⁵

One of the major areas we continue to encounter challenges in balancing and manning our force is our critical Military Occupational Specialties (MOS) shortages in skill level 3 and 4 leaders which are being reported on monthly Unit Status Reports – USRs. In many cases, these critical MOS skill sets are being replaced with inexperienced skill level 1 Soldiers initially enlisting in the Army.⁵⁶ These challenges are compounded by dilemmas the Human Resource Command (HRC) endures in screening Soldiers who are placed on Permanent Change of Stations (PCS) orders to fill shortage MOS authorizations within deploying units. The process of screening Soldiers' medical profiles and personnel files to determine their deployable status prior to PCS'ing to their gaining installation and unit is inadequate or does not exist. Many times, this result in some "non-deployable" Soldiers being reassigned to deploying units. These factors

combine to create additional challenges for units working diligently to meet the designated 90 to 95% deployable criteria. While serving as the Deputy Commander, 1st Cavalry Division (Rear) (Provisional) from July 2006 to February 2008, I experienced these tremendous challenges first hand.

Battlefield Experiences and Challenges Maybe Impacting Soldiers & Leaders

Today's battlefield requires that our forces be capable of supporting full spectrum operations which includes offense, defense, and stability operations. It also requires a force that is agile, flexible, and adaptable in order to support volatile, uncertain, complex, and ambiguous (VUCA) operational environments. In an essay by LTG David Barno, he suggests that the theater level command in an irregular warfare setting demands a broader set of skills than those required of conventional war at the same level. He also contends that our military leaders today are superbly trained and equipped by their lifelong experience to lead difficult military contingency operations anywhere in the world. However, our leaders fall short in understanding the leadership requirements across an increasingly important non-military sphere and their centrality to success in irregular warfare.⁵⁷

Since toppling the former Iraqi regime, our Armed Forces have encountered Irregular Warfare (IW) that consists primarily of insurgency operations in which we were untrained and ill-prepared to engage. Prior to Operation Iraqi Freedom, the focus of our Army's Mission Essential Task List (METL) and training were primarily focused on Major Combat Operations (MCOs). Today's war-fighting environments require a force that is trained and prepared to operate within three different types of conflicts - MCOs, counterinsurgency (COIN), and counter terrorism (CT). Additionally, the lack of civil resources in these conflicts settings has forced our military leaders to play a very large

role in the 80% non-military dimension of irregular warfare and stability operations (see endnote for additional information).⁵⁸

Senior military leaders have limited experience and often even less preparation for this role; although over eight years of war in Iraq and Afghanistan have now provided some hard-won knowledge that is slowly becoming more common at senior levels.⁵⁹ Although we have made great progress in training and preparing a force that is now capable of executing COIN and CT operations, our forces have encountered “asymmetrical warfare,” fighting a conflict that is strained by constant changes to rules of engagement (ROE) while encountering non-state actors and an enemy who practices non-traditional and unconventional tactics. Unlike previous conflicts where there was traditional front and rear boundaries or a near and deep battlefield, today’s conflict is on a 360 degree battlefield.

Over the past eight plus years, we have been primarily engaged in war and warfare with “non-state” actors as opposed to Armed Forces of another country. Al Qaeda and the Taliban have continuously used unconventional tactics (irregular warfare) such as improvised explosive devices (IEDs), vehicle born improvised explosive devices (VIEDs), snipers, and ambushes. Our Soldiers are not facing an organized enemy in uniform, but rather an enemy who elects to blend in with the local populace. They generally wait for the ideal moment to employ IEDs and/or employ humans strapped to bombs (human suicide bombers) as well as the use of car bombs to wage mental and psychological warfare while inflicting numerous casualties upon our forces and the local populaces. The majority of our combat casualties over the past eight years have resulted from IEDs, VIEDs, and human bombs.

In many cases, Soldiers are witnessing the serious injuries and death of their comrades, not while engaged in force-on-force combat operations, but while maneuvering in convoys and being ambushed by IEDs (see endnote for further explanation).⁶⁰ In many instances our servicemen and women are unable to initiate contact with the enemy. Instead, they are consistently being attacked sporadically, and are sustaining substantial casualties both mentally and physically. Dealing with the complexity, uncertainty, volatile, and ambiguous nature of this type of warfare may increase the number of mental health conditions sustained by our Soldiers.

As we move forward in reducing our emphasis and focus in Iraq, we are beginning to see a decrease in unconventional tactics being employed in this region. Simultaneously, as we now shift our focus to Operation Enduring Freedom and on winning the war in Afghanistan (defeating Al-Qaeda, better governance, and a trained Afghan Security Force) we have seen a rise in these tactics being employed in this region. This has resulted in an increased number of American and coalition casualties sustained over the past several months.

Historical Post-Conflict Funding Barriers Maybe Causing Acceleration Of Initiatives

As an institution, our Army's position has been centered on capitalizing on the huge increase in the total Army budget and supplements received to support war-fighting requirements and capabilities as a pillar for implementing initiatives that may have been otherwise constrained during peacetime due to reduced Army budget ceilings. In essence, the transformation and modularity of our Army are linked to OCO to validate the purpose for executing several major initiatives while funding for war-fighting requirements is primarily unconstrained.

By Fiscal Years (FY) 2012 and FY2013, it is anticipated that the Department of Defense (DOD), and more specifically, the Department of the Army (DA) will experience significant budget reductions. Consequently, any delay in the implementation of initiatives is likely to encounter many barriers – with a future reduced budget emerging as the leading constraint. Historically, the DA's budget increases to support wars and major conflicts has been followed by a significant reduction in the post-conflict period. These reductions have included the Army significantly reducing the size of its overall force manning (end-strength). Evidence of these trends was seen following the end of WWI, WWII, the Korean War, and after Operation Desert Storm when our Army experienced a significant reduction in its end strength and budget. Figure 4 provides an illustration showing how the Department of the Defense and the Department of the Army's budget percentages peaked during war:

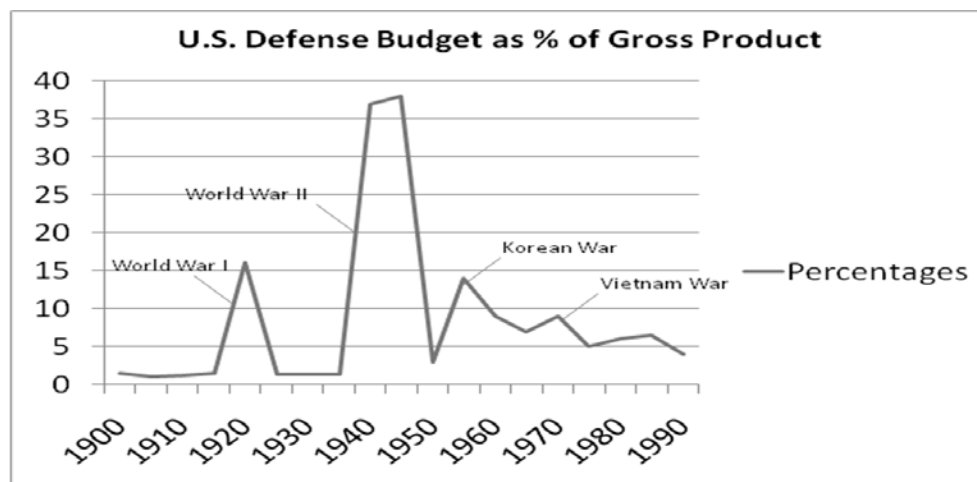


Figure 4: U.S. Defense Budget as Percentage of Gross Domestic Product; figure not to scale⁶¹

A monograph authored by Dr. Dennis S. Ippolito from the Strategic Studies Institute contends that the fiscal obstacle confronting defense planners are formidable. That report contends that the fiscal realities have often compromised military

capabilities in the past and may do so again in the near future. It also suggests that the short-term threat to defense spending is tied to deficit control. Consequently, defense programs will compete with domestic programs for a shrinking share of the budget. The politics of this debate will probably prove costly for the Department of Defense.⁶²

Changing Our Culture In Order To Embrace Growing Medical Conditions

Our Army has made tremendous progress in eliminating a “zero defect” mentality. However, in order for Soldiers and leaders to feel secure in openly coming forward in seeking help for their mental health challenges, we must create an institutional climate that unconditionally embraces these mental health and psychological medical conditions without reservations. We must inculcate this change throughout our Army.

Our internal organizational culture enables us to effectively change our overall strategy to align with the evolving environment. However, our history suggests that our Army, as an institution, finds that change is difficult. Secretary of Defense Robert Gates stated the following regarding cultural changes:

The culture of any large organization takes a long time to change. The really tough part is preserving those elements of the culture that strengthen the institution and motivate the people in it while shedding those elements of the culture that are barriers to progress and achieving the mission.⁶³

Our Army must be as diverse as the people we represent. Our institution is made up of men and women from every city and town throughout America, and, in many cases, from several countries around the world. They have come together in order to form a “band of brothers” that is strong and unique to any other form of business or environment. Leaders throughout our Army can assist in influencing the needed change by fully adopting and grasping the fundamental aspects and intent the change is

designed to bring about. We must effectively promote and incorporate this change by ensuring the goals and parameters established by the strategic leader are clearly articulated. General (Retired) Gordon Sullivan contends that in order to posture communities and organizations for successful adaptation to the future, strategic leaders need to be attuned to variables such as accelerating rates of change and advances in science and technology that will shape the future environment.⁶⁴

If we don't change our institutional culture by creating an internal environment that provides Soldiers and leaders the confidence needed to come forth in seeking support, we may witness some serious challenges and incidents resulting from these problems. A research study conducted in both military and civilian populations on the long-term effects of PTSD, depression, or TBI suggests that, unless treated, each of these conditions has implications that are wide-ranging and negative for those afflicted.⁶⁵ Thus, the effects of post-combat mental health and cognitive conditions can be compared to ripples spreading outward on a pond. However, whereas ripples diminish over time, the consequences of mental health conditions may grow more severe, especially if left untreated.⁶⁶

Our Army is moving forward in tackling many of the strategic implications of the transformational changes taking place. At the same time, we are also experiencing an increased number of Soldiers diagnosed with or demonstrating symptoms of PTSD, major depression, TBI. As a result, we are in the process of implementing several programs such as the *Comprehensive Soldiers Fitness* program. However, part of our overarching strategy must include changing our culture to one that is more accepting and one that embraces these challenges by starting at the top of our leadership;

inculcating change throughout our Army. By better understanding the profound impact of these illnesses, we will enable Soldiers to swiftly seek and receive the quality health care needed. A sincere acceptance by leaders in supporting these endeavors will hopefully lead to Soldiers and leaders developing the sense of confidence needed to openly come forward in seeking the help needed in coping with these troubling conditions. It will also aid in sustaining cohesive and disciplined units when Soldiers know that their leaders truly care about their health and well-being.

Overhauling VA to Support the Mental Healthcare Needs of Our Veterans

Several senior ranking officials within the Department of Veterans Affairs are concerned about the ability of the VA to meet the growing demand of veterans from the Iraq and Afghanistan war who are seeking mental health care through the VA. A recent report indicates that 830,000 claims were filed last year, which is a 25% increase over previous years. Officials believe that this increase is only one of several factors that have caused a lengthy delay in providing adequate care and assistance to veterans. Other factors include inadequate budgetary limitations to expand the health care services and hire additional healthcare providers needed to assist veterans; claims are highly complex and require medical problem claims to be linked to veterans' military medical records; and a claims process that allows veterans to add information to their claims at any time which prolongs the claims process.⁶⁷

In addition to these mounting concerns, VA has also acknowledged that the number of veterans committing suicide is growing at an alarming rate.⁶⁸ Internal VA reports suggest that approximately 18 veterans per day are committing suicide. As a result of this growing trend, the VA has made suicide prevention a priority, instituting new measures over the past year and a half, including training its workers to identify

suicidal patients and establishing a 24-hour suicide hotline for veterans. As the largest health care system in the country with a large and complex organization, it takes time for changes to be implemented throughout the VA system.⁶⁹

Over the past several years, the number of veterans seeking health care needs from the VA has been consistently underestimated. In Fiscal Year 2007, VA underestimated the number of veterans who sought VA health care support by 100,000 patients, equating to approximately 100%. In 2008, a report to the Senate suggested that VA's projections in its budget request fell short of actual demands by approximately 50,000 patients. This shortfall led Senate approval of \$229 million emergency funding to ensure that VA would be able to address funding shortfalls to meet the needs of veterans without impacting the services for other VA patients. Additionally, the Senate approved a \$100 million budget provided to VA to support initiatives to improve veterans' mental health services; \$20 million for substance abuse programs; and \$20 million for Veterans Centers and Readjustment Counseling.⁷⁰

In November 2008, Congressman Bob Filner, the head of the House Veterans Affairs Committee, suggested that VA created a "culture of dishonesty" over the way it has treated some of the more than 350,000 Iraq and Afghanistan war veterans under its care. Congressman Filner believes that VA is now at a "critical juncture" and "is on the verge of completely losing the trust and confidence of the people that it is supposed to represent...the very same people it has been entrusted to care for."⁷¹

On December 7, 2008, in a bold move in the right direction in changing the image created by the VA, President Barack Obama chose retired General Eric Shinseki, a Vietnam war veteran, to lead the Department of Veteran Affairs. This decision sends a

clear message to the hundreds of thousands of Iraq and Afghanistan war veterans that America takes their sacrifices seriously.⁷²

In a sincere effort to improve the quality of medical care provided to our veterans, the Department of Veteran Affairs is working diligently to change its culture while researching and implementing programs to ensure it is able to effectively care for the growing number of veterans seeking assistance for severe depression, PTSD, and TBI, and their symptoms. The VA is also working to overhaul its bureaucratic system that makes it challenging for veterans in getting the proper medical care needed in overcoming their medical and mental health challenges. Their overall objective is to streamline processes and procedures in a concerted effort to make care seamless, as well as move to increase the number of medical professionals available in administering proper care for our Nation's veterans.⁷³

There have also been recent procedural changes within VA in the way they are enabling veterans who believe they are suffering from symptoms of major depression, PTSD and TBI. The National Center for PTSD indicates that there are a variety of differences between the contexts of care for active duty military personnel and veterans normally being served by VA that may affect the way practitioners go about their business. The report suggests that many Iraq war patients will not be seeking mental health treatment. Some will have been evacuated for mental health or medical reasons and brought to VA, perhaps reluctant to acknowledge their emotional distress and almost certainly reluctant to consider themselves as having a mental health disorder (i.e., PTSD). It further states that emphasis on diagnosis as an organizing principle of mental health care is common in the VA. Patients are given Diagnostic and Statistical

Manual of Mental Disorders, Fourth edition (DSM-IV) diagnoses, and diagnoses drive treatment. This approach may be contrasted with that of frontline psychiatry, in which “pathologization” of combat stress reactions is strenuously avoided. DSM-IV is a diagnostic manual and PTSD is a mental disorder in it. Being diagnosed with a mental disorder is “stigmatizing” in both our society and our military.⁷⁴

Although the Veterans Affairs office is making progress in its efforts to meet the demands of the growing number of veterans seeking medical care, it must work relentlessly in its efforts to adopt a vision that includes swiftly and completely addressing and caring for the medical concerns and needs of our veterans as soon as they visit a VA facility. This support should be administered without red tape, delay, stigma or discrimination. In order to adopt this vision, the VA must be adequately funded and resourced by our Congress.⁷⁵

Some Recommended Resolutions

The current health care initiatives that are being implemented do not go far enough in creating a coherent strategic framework that helps to make it apparent that progress is being made in working to effectively assist Soldiers and their families in combating the growing challenges associated with mental health conditions. As senior leaders, we must acknowledge and embrace this fact and work to balance our efforts in training and caring for the mental health of our forces. In essence, we must eliminate the stigma of seeking care by doing a better job in educating and training our force in comprehending the affects PTSD, TBI and major depression imposes on the human dimensions and on the readiness posture of our Army.

Providing our leaders better training on mental health issues is critical to sustaining our forces in a prolonged war. In short, we must become proactive versus

reactive in combating the mental health challenges that are increasing within our Soldiers. It is imperative that leaders at all levels develop a comprehensive understanding of the nature of mental health and psychological medical conditions facing themselves and those they lead. These efforts require greater leader engagement and more deliberate focus on the impacts and cumulative effects that war and warfare imposes on the human dimension.

Accordingly, our Army is also exploring other avenues to enhance Soldiers by instituting mental health resilience training at every level, from basic training to the war college. For example, to cope with some of the growing challenges we face with an increased number of Soldiers contemplating and/or committing suicide, our Army is seeking assistance from outside psychiatrists and psychologists in developing and implementing a program called the *Comprehensive Soldiers Fitness* that emphasizes keeping Soldiers both mentally and physically fit. This program is designed to comprehensively equip and train Soldiers, Families members, and Department of Defense civilians to maximize their potential and face the physical and psychological challenges of sustained operations. Additionally, our Army is also developing “Master Resilience” trainers, the mental health equivalent of master fitness trainers. The Master Resilience course is designed to teach resilience skills to Soldiers and Family members. Two other programs include the *Beyond the Front* and the *Ask, Care, and Escort (ACE)* programs. The *Beyond the Front* program is an interactive learning and decision-making software program designed to realistically depict deployment settings and Army cultural norms to better reach the intended audience of recently deployed Soldiers. The

ACE program augments and reinforces the *Beyond the Front* software program. Both programs have been instituted by the Army as key prevention programs.⁷⁶

In essence, the Army is adopting a prevention model, targeting our entire force, enhancing resilience and coping skills that will enable all involved to grow and thrive in today's Army.⁷⁷ All of these programs are a part of the Army's overall strategy of Comprehensive Soldiers Fitness which is intended to increase resilience and enhance performance by developing the five dimensions of strength: social, emotional, spiritual, physical and Family.⁷⁸ These programs and other initiatives could not have come at a more critical time.

As the Rand study confirmed, the invisible wounds of war are rapidly increasing, although many efforts to identify and treat those wounds are already underway. However, Rand notes that the systems of care are not yet fully available to assist recovery for TBI, PTSD, and major depression.⁷⁹ The study offers four recommendations to assist in overcoming the tremendous challenges facing our Soldiers and veterans: (1) we must increase the cadre of providers who are trained and certified to deliver evidence-based care, so that capacity is adequate for current and future needs; (2) change policies to encourage active duty personnel and veterans to seek needed care; (3) and invest in research to close information gaps and plan effectively.⁸⁰

To further expand on the recommendations suggested by Rand, an increase in the number of care providers who are trained and certified to deliver proven care includes the following:

1. Adjustment of financial reimbursement for providers to offer appropriate compensation and incentives to attract and retain highly qualified professionals and ensure motivation for delivering quality care.

2. Develop a certification process to document the qualification of providers. Rather than rely on a system in which any licensed counselor is assumed to have all necessary skills regardless of training, certification should confirm that a provider is trained to use specific evidence-based treatment for specific conditions.

3. Expansion of existing training programs for psychiatrists, psychologists, social workers, marriage and family therapists, and other counselors. Programs should include training in specific therapies related to trauma and to military culture.

4. Establishment of regional training centers for joint training of DoD, VA, and civilian providers in evidence-based care for PTSD and major depression. This training could occur in coordination with or through the Department of Health and Human Services. Training should be standardized across training centers to ensure both consistency and increased fidelity in treatment delivery.⁸¹

Changing policy to encourage active duty personnel and veterans to seek needed care would require resolving many practical challenges. However, this is vital for addressing the mental health problems of those service men and women who are not seeking care because they are concerned for their military careers.⁸² In 2008, Secretary of Defense Robert Gates announced that seeking mental health care due to PTSD would no longer be seen as an obstacle to service members qualifying for a government security clearance.⁸³

The military has implemented other initiatives such as the Military and Family Life Consultant (MFLC) program. This programs has proven to be invaluable, providing Soldiers and Families twelve sessions of non-medical, short-term counseling sessions addressing concerns such as anger management, stress, parenting, communication, family relationship, deployment, and other military related topics. The overarching goal of this program is to support operational readiness and family readiness.⁸⁴ Further changes to policy should include incorporation the following:

1. Develop ways for service members to seek mental health care voluntarily and off-the-record, including ways to allow service members to seek this care off-base if they prefer and ways to pay for confidential mental health care (that is, not necessarily tied to an insurance claim from the individual service member). Thus, the care would be offered to military personnel without mandating disclosure, unless the service member chooses to disclose use of mental health care or there is a command-initiated referral to mental health care.

2. Make the system transparent to service members so that they understand how information about mental health services is and is not used. Such transparency may help mitigate service members' concerns about how mental health interventions may or may not prove a detriment to their careers.⁸⁵

Our senior leaders need to better understand what is needed to address the full range of problems (emotional, economic, social, health, and other quality-of-life deficits) that confront individuals with post-combat PTSD, major depression, and TBI. This knowledge is required both to enable the health care system to respond effectively and to calibrate how disability benefits are ultimately determined. The DoD Center for

Deployment Health has initiated studies in determining the natural course of these mental health and cognitive conditions among OEF/OIF veterans, including predictors of relapse and recovery. The DoD Center for Deployment Health is in the process of compiling data on pre-deployment, during deployment, and at multiple stages post-deployment.⁸⁶ This research which is designed to close the gaps in planning effectively also includes the following: Developing generalized for all deployed service members, while still facilitating identification of those at highest risk, and focusing on the causal associations between deployment and mental health conditions.⁸⁷

While these great initiatives and recommendations will definitely support the increasingly and cumulative effects of combat stress that our Soldiers are experiencing, we must do more. Our Army must work to balance our force in order to meet the future demands of our Nation. It is imperative that today's solution does not cause tomorrow's problems. Our Army must ensure that we have a trained, experienced, and capable force needed to support future conflicts.

Subsequently, we must transform our internal cultural into one of acceptance and one that sincerely encourages Soldiers to come forth in seeking help, building an institutional environment free of fear. According to Terri Tanielian, a researcher at Rand, we need to remove the institutional cultural barriers that discourage Soldiers from seeking care. Mrs. Tanielian further states that just because someone is getting mental health care does not mean that they are not able to do their job. Seeking mental health treatment should be seen as a sign of strength and interest in getting better, not a weakness. Our Soldiers need to get help as early as possible, not only once their symptoms become severe and disabling.⁸⁸

We must build the time necessary to support and care for the growing medical needs of our forces by allocating adequate personnel and resources to support the continuing emerging requirements. Unless our Soldiers and veterans receive appropriate and effective care for their mental health and psychological conditions, there could be long-term consequences for them and our Nation as well as impact the readiness posture of the Army in the future. Leadership awareness must include understanding the nature of the growing medical challenges confronting our Soldiers. This requires building the capacity to balance time associated with training, equipping, and preparing for future deployments with training, maintaining and caring for the needs of our Soldiers.

We must continue to conduct studies and cost analyses to effectively identify the costs associated with building the medical infrastructure. This includes building, equipping, manning, training, caring, and resourcing to support the growing medical challenges facing our Soldiers. In the first analysis of its kind, researchers estimate that PTSD and depression among returning service members will cost the nation as much as \$6.2 billion in the two years following deployment – an amount that includes both direct medical care and costs for lost productivity and suicide.⁸⁹

Conclusion

In conclusion, over the past eight plus years, our Army has been actively engaged in supporting two major conflicts while simultaneously undergoing substantial efforts to transform our Army. This research paper has attempted to outline some of the potential complicating factors and challenges that compound the cumulative effects and strains continuous deployments have placed on the readiness posture of our Army. The number of Soldiers developing symptoms and being diagnosed with PTSD, TBI and

major depression continues to grow at an alarming rate. It is imperative that we not only recognize and acknowledge these critical problems, we must also move now to change our culture while placing significant emphasis on better comprehending and pursuing quality care for the mental health and welfare of our Soldiers and their Families.

This requires our Army to re-examine its current Strategic Communication (STRATCOM) position and priorities for implementing numerous internal initiatives during a period in which our operational tempo (OPTEMPO) is at an all time high. Currently, there is no coherent strategy that helps to make it apparent that progress is being achieved in combating mental health conditions. Our Soldiers are consistently volunteering to serve our great Nation, and are prepared, if needed, to do our Nation's bidding. Secretary of Defense Robert Gates stated:

No one expected major combat operations in Iraq to go on this long; to deploy on multiple and sometimes extended deployments, the stress of battle, the wounds of war, both seen and unseen. All of this has taken its toll on our troops and their Families.⁹⁰

Strategic leaders must clearly see the big picture to fully grasp and completely understand the strategic implications of these growing mental health conditions and how they impact the future readiness of our Army. As strategic and senior leaders, we must move forward to create a climate and foster an environment that will ensure that our servicemen and women are provided the best possible medical care possible in overcoming the tremendous challenges they are consistently facing in battling mental health and psychological conditions which include PTSD, TBI, and major depression. Our Army, as an institution, is implementing a number of new and innovative programs designed to ensure that Soldiers and their Families are fully capable of seeking support

for their growing mental health challenges while working to enhance the level of quality care they are currently receiving.

Our Army is pursuing deliberate efforts to balance our force in order to meet future demands. However, this must be done with more fidelity and efficiency. This process must include developing strategic courses of actions that will enforce the established deployment dwell time ratio (1:2 for active duty and 1:4 for Reservist), and afford Soldiers the opportunity to spend more time re-integrating with their families while simultaneously enabling them opportunities to fully recover from the enormous toll eight plus years of war has taken upon their physical and mental wellbeing.

For reasons mentioned earlier, primarily funding, the Army has elected to execute internal initiatives while fighting two wars which prevents Soldiers from effectively seeking needed quality health care and spending the time necessary to fully re-integrate with their families. The growing number of Soldiers being diagnosed with PTSD, major depression, and TBI, in essence, resulted in our Army fighting “three” wars simultaneously. The third being a war on mental health challenges (the psychological effects and strains place on the human dimension). This persistent war on mental health challenges has had a profound impact on the physical and mental readiness of our force. These factors have consistently reduced the number of Soldiers available within our operating force and have placed enormous pressure on our generating force, challenging it to produce and sustain additional capabilities. Studies are consistently revealing that mental health related conditions continue to lead all categories of casualties our Army has endured.

Inculcating unconditional support to our Soldiers suffering from PTSD, TBI and major depression must become a “Top-Down” approach. In order for leaders at every level to support, embrace, and change the way we think and act about mental health challenges, we must foster a cultural change that is supported by our strategic leaders; with no exceptions. Additionally, unlike Vietnam, when our Army hasteningly released service members back into a society who had already condemned America’s participation in Vietnam, we must move forward in building an institution that is fully capable of caring for the growing medical needs and concerns of our forces who have courageously answered the call to duty in volunteering to serve our grateful Nation in combating terrorism around the world.

This process starts by changing our internal culture of how we recognize and embrace the tremendous increase in the number of the combat stress reactions that are constantly affecting our men and women in uniform; fostering an environment centered on acceptance versus denial. We must also build trust and confidence between Soldiers and their leaders in confronting combat stress reactions. The close habitual relationship between leaders and those they lead will enable Soldiers to feel secure in bringing their mental health conditions to the forefront. As suggested by a Rand report, this process should start by creating a system that would allow service members to receive mental health services confidentially in order to ease concerns about negative career repercussions.⁹¹

Lastly, today’s solutions, as they relate to instituting great internal Army initiatives (including Army transformation efforts), while placing inadequate emphasis on dealing with a rapidly growing medical problem affecting our Soldiers, may potentially cause

tomorrow's major problems affecting not only our institution as a whole, but affecting our society. If not addressed in a timely and holistic manner, the strategic implications may prove catastrophic.

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